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FOR
TRICARE/CHAMPUS POLICY MANUAL

THE TRICARE MANAGEMENT ACTIVITY HAS AUTHORIZED THE FOLLOWING ADDITION(S)/REVISION(S) TO THE TRICARE/CHAMPUS POLICY MANUAL

REVISION(S)

CHAPTER(S): 1; 3; 4; 5; 6; 7; 8; 9; 10; 11; 12; 13

SECTION(S): TOC, 1.1, 10.1, 12.1G, 12.3, 12.5, 12.7, 12.9, 17.3, 21.1; 25.1, 25.3; 1.3, 2.6, 2.9, 5.6, 6.1, 13.2, 17.3; 1.6, 5.1; TOC, 4.1; 2.4; 5.3, 7.1, 8.1; 3.2, 6.1, 14.1, 21.2, 24.1, 26.1; TOC, 14.3; 2.10; 2.1, 8.1, 9.1, 11.7; 1.1, 2.1, 3.1, 7.3, 8.1, 8.2, 9.1; TOC, 1.3, 1.5, 3.4, 3.5, 3.6, 3.10, 4.2, 6.1D, 6.5, 6.7, 9.1, 14.1, 16.1, 24.1; Addendum 4-Table 3, Addendum 7; Appendix C.

ADDITION(S)

CHAPTER(S): 13

SECTION(S): 16.1-Addendum 1,2 and 3.

DELETION(S): Chapter 1, Section 12.4; and Chapter 9, Section 6.1.

REMOVE PAGE(S): See pages 2-5 of this transmittal.

INSERT: ATTACHED ADDITIONAL/REPLACEMENT PAGE(S): See pages 2-5 of this transmittal.

SUMMARY OF ADDITIONS/REVISIONS: See pages 6-12 of this transmittal.

EFFECTIVE DATE AND IMPLEMENTATION: The Effective Date is as indicated on the attached pages. Implementation is upon direction of the Contracting Officer.

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Barbara J. Gallegos
Director, Office of Medical Benefits
And Reimbursement Systems

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 1.1 (SEXUAL DYSFUNCTIONS, PARAPHILIAS AND GENDER IDENTITY DISORDERS) was revised to clarify intent of policy.
2. Section 10.1 (TRICARE/CHAMPUS STANDARD – CLINICAL PREVENTIVE SERVICES) adds guidance for using diagnosis codes V76.11 and V76.12, and corrects a typographical error.
3. Section 12.1G (PARTIAL HOSPITALIZATION PROGRAM) clarifies the billing of professional services outside the partial hospitalization per diem rate.
4. Section 12.3 (ATTENTION DEFICIT/HYPERACTIVITY DISORDER) excludes Test of Variables of Attention (T.O.V.A.®).
5. Section 12.4 (OUTPATIENT PSYCHOTHERAPY) was deleted in its entirety and coverage is incorporated in Chapter 1, Section 12.7.
6. Section 12.5 (TREATMENT OF MENTAL DISORDERS) updates citations; changes TSO to TMA; deletes paragraph B under the EXCEPTIONS section; changes Exceptions to Exclusions; deletes paragraph B under Policy Considerations; and clarified exclusions.
7. Section 12.7 (PSYCHOTHERAPY) updates the policy for clarity by deleting the second paragraph under POLICY CONSIDERATIONS. In addition, policy criteria from Chapter 1, Section 12.4 have been added.
8. Section 12.9 (PSYCHOTROPIC PHARMACOLOGIC MANAGEMENT) was revised for clarity.
9. Section 17.3 (SPEECH PATHOLOGY SERVICES) updates the authority citation and procedure code range; and revises ‘CONSIDERATIONS’ paragraph A.4.a. by removing references to specified frequencies and replacing with less prescriptive language; and adds a qualifier to the policy that coverage of the service is dependent on a reasonable expectation of improved conditions.
10. Section 21.1 (ALLERGY TESTING AND TREATMENT) updates policy coverage and claims processing instructions.
11. Section 25.1 (PHYSICAL THERAPY) updates the procedure code range and clarifies the initial claims adjudication requirements.
12. Section 25.3 (OCCUPATIONAL THERAPY) updates procedure code range; and adds a qualifier to the policy that coverage of the service is dependent on a reasonable expectation of improved conditions.

CHAPTER 3

13. Section 1.3 (LASER SURGERY) was rewritten for clarification.
14. Section 2.6 (POSTMASTECTOMY RECONSTRUCTIVE BREAST SURGERY) clarifies that nipple/areolar tattoo is a current benefit under TRICARE.
15. Section 2.9 (SILICONE OR SALINE BREAST IMPLANT REMOVAL) under Exception B clarifies that the conditions listed are considered unfortunate sequelae resulting from the initial non-covered surgery.
16. Section 5.6 (THERAPEUTIC APHERESIS) clarifies that symptomatic monoclonal gammopathy is included under multiple myeloma.
17. Section 6.1 (HIGH DOSE CHEMOTHERAPY WITH STEM CELL TRANSPLANT) clarifies the policy by (1) moving donor lymphocyte infusion to a separate paragraph; (2) changing the language to read unirradiated donor lymphocyte infusion (buffy coat infusion, donor leukocyte infusion or donor monoculear cell infusion); and (3) adding myelocytic, myelogenous, myeloblastic or myelomonoblastic for clarity. The policy adds the following to the exclusion section:
    1. Donor lymphocyte infusion if not specifically listed as a benefit.
    2. HDC with allogeneic stem cell transplants for cold agglutinin disease.
    3. HDC/ABMT or PSCT for yolk sac tumor (endodermal sinus tumor).
    4. HDC with stem cell rescue for the treatment of ovarian cancer.
    5. Allogeneic BMT or PSCT with HDC for multiple myeloma.
18. Section 13.2 (MATERNITY CARE) clarifies coverage for expanded AFP; and replaced ‘CHAMPUS’ with ‘TRICARE’.
19. Section 17.3 (COCHLEAR IMPLANTS) clarifies reimbursement for cochlear implants under DRG, CMAC, and in ambulatory surgical centers; and adds that cochlear implants using FDA approved devices are covered when used in accordance with the labeled indications.

CHAPTER 4

20. Section 1.6 (SINGLE PHOTON EMISSION COMPUTED TOMOGRAPHY (SPECT) clarifies the policy by adding Indium-111 labeled anti-TAG72 for tumor recurrence and Indium 111 for detecting the presence and location of myocardial injury.
21. Section 5.1 (RADIONUCLIDE IMAGING PROCEDURES) updates the procedure code range.

CHAPTER 5

22. Section 4.1 (MATERNAL SERUM ALPHA-FETOPROTEIN SCREEN) updates policy to clarify coverage for Expanded AFP.

CHAPTER 6

23. Section 2.4 (CUSTODIAL CARE IN A HOSPITAL) reaffirms the policy.

CHAPTER 7

24. Section 5.3 (ORTHOTICS) adds L1200 to the range of codes for spinal orthotics; and deletes reference to CPT codes 21431-21436 for cranioplasty banding treatment.
25. Section 7.1 (DRUGS AND MEDICINES) excludes the following:
    1. Cyclosporine for treatment of severe aplastic anemia.
    2. Gemcitabine (GEMZAR®) for the treatment of non-small cell lung cancer.
    3. Interferon alfa-2b for treatment of bladder cancer.
    4. Pamidronate (AREDIA) for the treatment of osteoporosis.
    5. Taxol for the treatment of malignant melanoma.
    6. Transdermal nicotine patch for the treatment of ulcerative colitis.
26. Section 8.1 (OXYGEN AND OXYGEN SUPPLIES) clarifies the policy by adding that oxygen concentrators may be purchased or cost-shared on a rental basis.

CHAPTER 8

27. Section 3.2 (PROGRAM FOR PERSON WITH DISABILITIES (PFPWD): HEARING IMPAIRMENT CRITERIA) updates the procedure code range and revises the policy by removing the specified testing frequencies.
28. Section 6.1 (CUSTODIAL CARE) adds reference to acute hospital care relating to custodial care.
29. Section 14.1 (UNPROVEN DEVICES, MEDICAL TREATMENT, AND PROCEDURES) adds the following procedures:
    1. Adoptive immunotherapy involving the infusion of tumor infiltrating lymphocytes (TIL) for the treatment of cancer.
    2. Allogeneic BMT for treatment of multiple myeloma and Hodgkin's disease.
    3. Allogeneic PSCT for non-Hodgkin's lymphoma.
    4. Bullectomy for lung volume reduction.
    5. Donor lymphocyte infusion (donor buffy coat infusion, donor leukocyte infusion, donor mononuclear cell infusion) except for patients with CML who relapse following HDC with allogeneic BMT.
    6. Epidural steroid injections for thoracic pain.

CHAPTER 8 (cont.)

7. Eye movement desensitization reprocessing therapy for treatment of anxiety-related disorder.
8. HDC with stem cell rescue for yolk sac tumor (endodermal sinus tumor).
9. HDC with allogeneic stem cell transplants for cold agglutinin disease.
10. Heart-kidney and multivisceral to the list of exceptions for organ transplants.
11. Meniscal transplant (allograft).
12. Neurofeedback.
13. Percutaneous interstitial thermal ablation for the treatment of hepatic cancer.
14. Photopheresis for indications other than for treatment of skin manifestations (CTCL) in persons who have not yet been responsive to other forms of treatment.
15. Proton Beam radiosurgery for high-grade glioma (glioblastoma multiforme).
16. Synaptic 2000 for acute and chronic pain.
17. Test of Variables of Attention (T.O.V.A.®) for diagnosing attention deficit hyperactivity disorder and titrating pharmacotherapy levels.
18. TIPS revised to add recurrent and numerous non-covered conditions.
19. Transdermal nicotine therapy used to treat ulcerative colitis.
20. Transurethral needle ablation (TUNA) of the prostate.

The following procedures have been reaffirmed:

1. HDC with stem cell rescue for ovarian cancer.
2. Hyperosmolar blood-brain barrier disruption.
3. Lung volume reduction surgery.
4. Transjugular Intrahepatic Portosystemic Shunt (TIPS).
5. Transcervical block silicone plug.
6. Single-averaged ECG.
7. Single photon emission computed tomography (SPECT).

30. Section 21.2 (SUBSTANCE USE DISORDERS) revises the cross-references and clarifies waiver responsibility and the rehabilitation benefit under substance use disorders.
31. Section 24.1 (GYNECOMASTIA) was revised to clarify that treatment of gynecomastia purely for psychological reasons is not covered.

32. Section 26.1 (PHARMACY BENEFIT FOR MEDICARE ELIGIBLES AGE 65 AND OVER-BRAC AREA) clarifies benefits for prescription drugs for individuals who are not eligible for TRICARE/CHAMPUS solely because of their eligibility for Part A Medicare.

CHAPTER 9

33. Section 6.1 (CUSTODIAL PROVISIONS AND ENTITLEMENT TO MEDICARE) was deleted its entirety.
34. Section 14.3 (PROGRAM FOR PERSONS WITH DIABILITIES (PFPWD): ELIGIBILITY QUALIFYING CONDITION: SERIOUS PHYSICAL DISABILITY) deletes the Hertz frequencies for hearing testing.

CHAPTER 10

35. Section 2.10 (CERTIFIED PHYSICIAN ASSISTANT) clarifies that Physician Assistants may write prescriptions if practicing within the scope of their license.

CHAPTER 11

36. Section 2.1 (NONAVAILABILITY STATEMENT (DD FORM 1251) FOR INPATIENT CARE AND SELECTED OUTPATIENT PROCEDURES) clarifies that the retroactive effective date should match the admission date.
37. Section 8.1 (MENTAL HEALTH TREATMENT UTILIZATION REVIEW SYSTEM) deletes paragraph ‘C’ that references Appendix A since the information is now obsolete.
38. Section 9.1 (SPECIAL AUTHORIZATION REQUIREMENTS) clarifies that a preauthorization is required for outpatient mental health care beyond eight visits in an enrollment period for Prime enrollees and for non-enrollees, the preauthorization requirement is eight visits in a fiscal year.
39. Section 11.7 (SUBSTANCE USE DISORDER REHABILITATION FACILITIES CERTIFICATION PROCESS) adds that a satellite substance abuse treatment facility does not require additional certification if the facility is hospital based and an authorized provider.

CHAPTER 12

40. Section 1.1 (TRICARE PRIME BALANCE BILLING) provides protection for TRICARE Prime enrollees from balance billing situations. PLEASE NOTE this change was inadvertently omitted from Policy Manual Change 29. Therefore, funding for this change is provided in Policy Manual Change 29.

CHAPTER 12 (cont.)

41. Section 2.1 (TRICARE-COSTS AND UNIFORM HMO BENEFIT) provides cost-sharing guidelines for non-enrollees receiving care outside the region of residence.
42. Section 3.1 (TRICARE PHARMACY BENEFITS) adds clarifying note regarding National Mail Order Pharmacy and policy criteria concerning quarterly report for pharmacy.
43. Section 7.3 (TRICARE - PRIME AND STATUS CHANGES) corrects an error as it pertains to pro-ration of the enrollment fee. The enrollment fee is to be pro-rated on a monthly basis.
44. Section 8.1 (TRICARE PRIME-CLINICAL PREVENTIVE SERVICES) clarifies that prime beneficiaries are allowed self-referral to either an optometrist or an ophthalmologist for preventive vision screening.
45. Section 8.2 (TRICARE OVERSEAS PROGRAM PRIME – CLINICAL PREVENTIVE SERVICES) clarifies that prime beneficiaries are allowed self-referral to either an optometrist or an ophthalmologist for preventive vision screening.
46. Section 9.1 (TRICARE PRIME – PRIMARY CARE MANAGERS) was revised to provide consistent guidelines when mental health related care is provided by a network provider.

CHAPTER 13

47. Section 1.3 (ALLOWABLE CHARGES – APPLICATION OF THE MAXIMUM ALLOWABLE PREVAILING CHARGE) expands and clarifies those services and procedures that have been frozen since May 1, 1992, and the process for new allowable charges established by the TRICARE/CHAMPUS contractors since that date.
48. Section 1.5 (ALLOWABLE CHARGES -- CHAMPUS MAXIMUM ALLOWALBE CHARGES - CMAC) shows CMAC changes adopted in fiscal 1999.
49. Section 3.4 (LABORATORY SERVICES) was revised to make the processing and payment of out-of-area laboratory tests consistent with the jurisdictional provisions under the Managed Care Support contracts.
50. Section 3.5 (AMBULANCE SERVICES) provides itemized requirements for filing of ambulance claims.
51. Section 3.6 (LEGEND DRUGS AND INSULIN) clarifies copayment and benefit for medical supplies to administer a prescription drug and insulin.
52. Section 3.10 (SKILLED NURSING SERVICES) adds the CPT code range 99343-99350 for acceptable home skilled nursing services; deletes the Policy Considerations Section except for 5.b; and corrects typographical errors.

CHAPTER 13 (cont.)

53. Section 4.2 (CHARGES FOR PROVIDER ADMINISTRATIVE EXPENSES) clarifies that separate charges for provider administrative expenses are not allowable.

54. Section 6.1D (HOSPITAL REIMBURSEMENT-CHAMPUS DRG-BASED PAYMENT SYSTEM (APPLICABILITY OF THE DRG SYSTEM) clarifies that designation as a sole community hospital applies only to the DRG-based and Inpatient Mental Health Per Diem payment systems; and modifies policy by removing reference to quarterly update of sole community hospital list.

55. Section 6.5 (HOSPITAL REIMBURSEMENT-CHAMPUS INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM) clarifies that designation as a sole community hospital applies only to the DRG-based and Inpatient Mental Health Per Diem payment systems; reinstated the use of substance use disorder DRGs 433 through 437 and 900 and 901 in psychiatric hospitals and units; and adds the inpatient mental health deflator for 1997.

56. Section 6.7 (PARTIAL HOSPITALIZATION PROGRAM) clarifies billing of primary/attending provider services outside the partial hospitalization per diem rate.

57. Section 9.1 (AMBULATORY SURGICAL CENTER REIMBURSEMENT) clarifies that designation as a sole community hospital applies only to the DRG-based and Inpatient Mental Health Per Diem payment systems; and that the ambulatory surgery group payment rates were initially calculated using the procedures described; and updates the agency's name to TMA.

58. Section 14.1 (CATASTROPHIC LOSS PROTECTION) was revised for clarity.

59. Section 16.1 (WAIVER OF LIABILITY) has been revised to further clarify waiver of liability including adding three flow-charts, and more examples.

60. Section 23.1 (PROVIDER CODING OF NON-INSTITUTIONAL SERVICES USING HCPCS) deleted the contractor requirement to develop the claim for a HCPCS code. (NOTE: This revision was submitted in the republished version of the Policy Manual dated December 1998. Therefore, this issuance was removed from this package.)

61. Section 24.1 (REDUCTION OF PAYMENT FOR NONCOMPLIANCE WITH UTILIZATION REVIEW REQUIREMENTS) clarifies that outpatient mental health after 8 visits is subject to payment reduction if provider fails to obtain preauthorization.

62. Addendum 4 provides Hospice rates for fiscal year 1999.

63. Addendum 7 updates guidelines for the calculation of individual RTC Per Diem rates.

64. Appendix C (formerly Appendix D) corrects a typographical error.